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ASSESSMENT OF COMORBID SUBSTANCE USE DISORDER AND POSTTRAUMATIC STRESS DISORDER

JENNIFER P. READ, ANDREAS R. BOLLINGER, AND ERICA SHARKANSKY

This chapter is designed to review theoretical and procedural approaches to the comprehensive assessment of comorbid substance use disorder–posttraumatic stress disorder (SUD–PTSD). We outline several widely used assessment measures as well as methods to enhance accurate assessment of PTSD and SUD symptoms, and we discuss the importance of assessing other comorbidities and present procedural and provider issues that may affect assessment.

EVALUATING TRAUMA, PTSD, AND SUD

Critical choices in the planning of an evaluation of comorbid SUD–PTSD pertain to (a) the *timing* of the assessment (i.e., when is the client most likely to provide reliable information) and (b) *measures and methods* of assessment (i.e., instruments to be used, corroborative methods).

A major concern in the assessment process is that any substance use by patients may minimize or mask PTSD symptoms. Thus, any assessment of PTSD should not occur while patients are actively drinking or drugging. PTSD assessment should ideally be conducted after the addicted individual has completed withdrawal. The withdrawal process will vary by person and by substance of abuse but will usually not exceed 1 week. Consultation with the patient's medical and psychological treatment team may help determine the patient's readiness for assessment. Diagnosing PTSD should be avoided when patients are in the acute stages of withdrawal (Hoffman & Sasaki, 1997; Saladin, Brady, Dansky, & Kilpatrick, 1995). Many withdrawal symptoms (e.g., sleep loss, nightmares, increased anxiety, and increases in

intrusion of traumatic cognitions) overlap or mirror symptoms of PTSD, thereby potentially inflating estimates of PTSD or other anxiety disorders (Abueg & Fairbank, 1991). Given that memory problems are associated with withdrawal, assessment of traumatic events and associated sequelae will be more reliable after initial detoxification.

Concurrent evaluation of PTSD and SUD does not need to be time or labor intensive. A variety of measures are available that can easily be included as part of a basic assessment protocol. We provide here brief descriptions of some of the most widely used assessment tools.

Self-Report Instruments

Several self-report instruments offer a time-efficient and effective method of evaluating trauma, PTSD, and SUD. These self-report instruments can be administered in a variety of clinical and research settings and do not require specialized training of clinical personnel.

Trauma

Assessment of traumatic exposure should include attention to both parts of *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychiatric Association, 1994) Criterion A: (a) A1, which requires experiencing or witnessing an event involving actual or threatened death or serious injury, or a threat to physical integrity, and (b) A2, which requires a response to such an event that involves intense fear, helplessness, or horror. Additional information regarding type, duration, and severity of the traumatic event may provide a better understanding of the event and its sequelae. We present self-administered instruments; interview schedules are available (e.g., the Traumatic Stress Schedule; Norris, 1990; see Norris & Riad, 1997, for more information).

The Trauma History Questionnaire (Green, 1995) is a brief self-report measure that gathers information about Criterion A and other stressful events. Information pertaining to the number of times a traumatic or stressful event occurred and the age of a patient at its occurrence is recorded. Reliability data demonstrate adequate test–retest reliability (Green, 1995, 1996).

Kubany and colleagues (2000) developed the Traumatic Life Events Questionnaire. Questionnaire items are described in behaviorally specific terms and evaluate *DSM–IV* A1 and A2 criteria and frequency of event occurrence. Emerging data on this measure suggest that it demonstrates adequate psychometric properties. Furthermore, this measure has been used successfully to assess trauma in substance-abusing populations.

PTSD

In this section we present self-report assessment instruments that offer the most promise in facilitating the detection of PTSD, particularly with respect to comorbid SUD–PTSD populations. Interested readers are referred to Norris and Riad (1997) for a more complete review.

The PTSD Symptom Scale–Self Report (PSS–SR; Foa, Riggs, Dancu, & Rothbaum, 1993) consists of 17 items designed to assess Criteria B, C, and D of the *DSM–III–R* (American Psychiatric Association, 1987) and *DSM–IV*. Falsetti, Resnick, Resick, and Kilpatrick (1993) modified the PSS–SR to measure symptom severity in addition to symptom frequency. This modified version of the PSS–SR (MPSS–SR) has demonstrated good psychometric properties in both treatment-seeking and community samples (Falsetti, Resick, Resnick, & Kilpatrick, 1992). Furthermore, this measure has been used successfully to assess PTSD symptoms in substance abuse populations and has shown strong sensitivity and specificity, as well as good reliability and validity, in these samples (Coffey, Dansky, Falsetti, Saladin, & Brady, 1998; Dansky, Saladin, Coffey, & Brady, 1997).

The PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993) uses a Likert-type scale to evaluate the extent to which an individual may experience each of the 17 *DSM* cardinal symptoms. This measure is available in both *DSM–III–R* and *DSM–IV* versions and has also been revised for use with civilian populations. It has strong psychometric properties and has been used with a variety of populations (e.g., Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), including people with SUDs (Najavits, Weiss, Reif, et al., 1998). However, the PTSD Checklist has not specifically been evaluated as an assessment measure to identify PTSD in SUD samples.

The Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995), which is based on the PSS–SR, consists of 49 items requiring respondents to rate symptom presence and severity on a Likert-type scale. Items are clustered around *DSM–IV* PTSD symptom clusters (re-experiencing, avoidance, and arousal). Early examination of the psychometric properties of the PDS have shown this measure to have good internal and test–retest reliability as well as strong convergent and concurrent validity. Although the PDS has been validated on a sample with diverse trauma experiences (Foa, Cashman, Jaycox, & Perry, 1997), its utility among SUD patients has not yet been established.

SUDs

Several self-report measures have been shown to be useful in screening for SUDs (see Miller, Westerberg, & Waldron, 1995). Despite the strengths of brief self-report measures, such instruments are insufficient for a formal

diagnosis of SUD. Moreover, there is a paucity of empirical research examining the utility of such self-report instruments for PTSD patients.

The Alcohol Use Disorders Identification Test (Babor, de la Fuente, Saunders, & Grant, 1992; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993) is a brief (10-item) measure that assesses alcohol consumption, drinking behavior, and alcohol-related problems. Its scores correlate with other self-report alcohol screening tests (J. P. Allen, Litten, Fertig, & Babor, 1997). Two other brief self-report measures with well-documented psychometric properties are the Michigan Alcoholism Screening Test (Selzer, 1971) and the Drug Abuse Screening Test (Skinner, 1982). Both measures, administered in either a paper-and-pencil or an interview format, can be used in a variety of settings with various populations.

Structured Clinical Interviews

Structured interviews in general tend to require clinical interviewers with specific training in the administration and scoring of the measures. Because of the level of detail that structured interviews cover with respect to symptomatology, they are generally viewed as confirmatory measures used to formulate a clinical diagnosis rather than as screening measures.

PTSD

Although numerous structured clinical interviews have been developed and used to assess PTSD (for reviews, see Carlson, 1997; Norris & Riad, 1997), here we highlight three of the most widely used. The Clinician-Administered PTSD Scale for *DSM–IV* (CAPS; Blake et al., 1995) assesses core and associated PTSD symptoms, both currently and over the course of the individual's lifetime (Blake et al., 1990). Presence, intensity, and frequency of each PTSD symptom in each of three symptom clusters (re-experiencing, avoidance, or hyperarousal) is assessed. The CAPS has been found to have excellent psychometric properties (Blake et al., 1995; Weathers & Litz, 1994). It has been shown to correlate significantly with other well-known measures of PTSD (Blake et al., 1995; Weathers & Litz, 1994) and has demonstrated strong diagnostic utility against the Structured Clinical Interview for the *DSM* (Weathers & Keane, 1999). Potential limitations of the CAPS include its length in administration and amount of training required for the interviewers. In addition, the intensity ratings for individual PTSD symptoms may be difficult to ascertain (Blake et al., 1995). At sites with limited clinical resources or more diverse client populations, a briefer interview, or even a self-report instrument, may be preferred.

The National Women's Study PTSD Module (Kilpatrick, Resnick, Saunders, & Best, 1989; Resnick, 1996) is a diagnostic interview that was

modified from the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981). The National Women's Study PTSD Module allows for the assessment of detailed information about a broad range of Criterion A traumatic events and B, C, and D symptoms. This measure is used for both men and women, has demonstrated good psychometric properties (Resnick, 1996; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), and has been administered to substance abuse populations (see Coffey et al., 1998; Dansky, Saladin, et al., 1997).

The PTSD module of the Structured Clinical Interview for *DSM–IV* (SCID; First, Spitzer, Gibbon, & Williams, 1994) is used in the assessment of PTSD and has excellent psychometric properties (Kulka et al., 1990; McFall, Smith, Roszell, Tarver, & Malas, 1990; Schnurr, Friedman, & Rosenberg, 1993). However, the SCID requires both a substantial amount of training and a professional clinician for administration, and it primarily yields categorical or dichotomous symptom ratings (S. N. Allen, 1994; Spitzer, Williams, Gibbon, & First, 1990). Furthermore, the symptom criteria do not have behaviorally anchored rating scales, and therefore there may be undesired subjectivity in the coding of a particular response. This measure lacks the precision of a more focused interview such as the CAPS (see Weiss, 1997).

SUDs

The SCID (First et al., 1994) is among the most popular structured interviews for the assessment of SUDs. The SCID has modules for alcohol as well as other classes of drugs. This measure yields a diagnosis of substance abuse or dependence and allows for specifiers such as *mild*, *moderate*, or *severe*, as well as the stage of the disorder (i.e., current diagnosis, partial or full remission). The SCID has demonstrated strong psychometric properties in the assessment of SUDs (Skre, Onstad, Torgersen, & Kringlen, 1991; Williams et al., 1992); however, the SCID requires rather extensive interviewer training, which can be time consuming and costly.

Another *DSM*-based measure used for assessing SUDs is the DIS (Robins et al., 1981), which was developed originally to gather epidemiological data regarding the prevalence of SUDs (see Miller, Westerberg, & Waldron, 1995). The DIS has demonstrated good psychometric properties (Levitan, Blouin, Navarro, & Hill, 1991; Malgady, Rogler, & Tryon, 1992) and has been found to be easy to administer in the assessment of substance abuse (Fleming & Barry, 1991). Unlike the SCID, the DIS requires little clinical training and does not require clinical judgment. Furthermore, the DIS is available in both paper-and-pencil and computer-administered formats.

Two other interviewer-administered measures that are widely used as part of a comprehensive assessment for SUD are the Addiction Severity

Index (ASI; McLellan et al., 1992), and the Timeline Follow-Back (TLFB; Sobell & Sobell, 1992). It is important to note that these two measures are not diagnostic measures per se; however, they are commonly used in both clinical and research settings to gather detailed information about substance use and related consequences.

The ASI assesses the severity of SUDs based on client functioning across several unique domains (measured by independent problem scales), including alcohol, drug, medical, employment, legal, family–social, and psychiatric. The ASI also assesses for emotional, physical, or sexual abuse. The ASI has been used with several diverse client populations (Appleby, Dyson, Altman, & Luchins, 1997; Joyner, Wright, & Devine, 1996; Leonhard, Mulvey, Gastfriend, & Shwartz, 2000; Weisner, McLellan, & Hunkeler, 2000) and has demonstrated strong psychometric properties (Appleby et al., 1997; McDermott et al., 1996; McLellan et al., 1992). The ASI has traditionally been used for evaluation of substance abuse populations, yet the comprehensiveness of this measure allows for its use in screening for trauma and PTSD as well as SUD. Najavits, Weiss, Reif, et al. (1998) noted that, although the ASI is not an effective measure for diagnosing PTSD, the trauma history items on this measure could serve to alert clinicians to the possibility that a client may have comorbid PTSD–SUD.

The TLFB procedure obtains a detailed picture of alcohol and other substance use behaviors. The TLFB is structured like a calendar and broken down month by month. Using this calendar, clients are asked to identify and note memorable occasions over the past 30 days to help prompt their recall of daily alcohol and other drug use behaviors over the past month. Use of the TLFB allows for a more comprehensive understanding of a client's daily drinking and drugging patterns. For example, by calculating a client's percentage of days abstinent, and number of drinks per drinking day, the percentage of days of heavy drinking can be derived. This measure has been shown to be a valid and reliable method for assessing substance use patterns over time (Sobell & Sobell, 1995).

Corroborative Evaluation Methods: Biological

In addition to self-report and structured interview methods, several biological methods for evaluating PTSD and SUD symptoms are available.

PTSD

Psychophysiological assessment methods are promising in that they potentially offer an unbiased way of deriving information about PTSD symptoms that does not rely on self-report data or on interviewer discretion and decisions. Psychophysiological assessments have typically focused on

measuring physiological responsiveness (i.e., autonomic arousal) when an individual is exposed to trauma-related stimuli (Blanchard, Kolb, Pallmeyer, & Gerardi, 1982; Blanchard, Kolb, & Prins, 1991; Everly & MacNeil-Horton, 1989; Gerardi, Blanchard, & Kolb, 1989). The assessment of autonomic arousal usually includes an electromyogram and measurements of heart rate, blood pressure, and galvanic skin response. The amount of required instrumentation and technical expertise necessary to obtain these measurements was at one time a significant practical limitation of this approach; however, advances in technology and increasing computer competence among practitioners have made psychophysiological assessment methods more viable (Orr & Kaloupek, 1997). This assessment approach may be particularly valuable in assessment contexts such as forensic or disability evaluations.

One disadvantage of psychophysiological assessment is its demonstrated poorer sensitivity than specificity, resulting in a significant number of false negatives. Thus, some relevant PTSD symptomatology may not be detected during the physiologic assessment process. Moreover, physiologic arousal is only one of several categories of posttraumatic stress symptoms; therefore, even in cases where physiologic assessment methods are implemented and used successfully to evaluate physiologic arousal in response to a stressor, not all of the PTSD criteria are being evaluated.

SUDs

Biological indicators, such as urinary or saliva analysis tests, can be used to assess use of alcohol or other drugs within approximately the past 24 hours (Bates, Brick, & White, 1993; Roffman & George, 1988; Washton, Stone, & Hendrickson, 1988). In addition, breath-analysis tests are commonly used to assess current blood alcohol concentration in patients and have been shown to provide reliable estimates (Bates et al., 1993). It is unlikely that such biological measures of recent alcohol use would flag ongoing, problematic use; however, such measures will maximize the likelihood that the person being assessed is not currently under the influence of alcohol or other substances, thus enhancing the reliability of the information derived from the assessment (e.g., Leigh & Skinner, 1988).

Elevated blood levels of gamma glutamyl transferase (GGT) and mean corpuscular volume (MCV) are among the most commonly used biological markers of problematic alcohol use (Anton, Stout, Roberts, & Allen, 1998; Leigh & Skinner, 1988). Although these markers have been linked to patterns of chronic alcohol abuse, they have not been demonstrated to reliably detect alcohol use disorders. Furthermore, they appear to add little to diagnostic accuracy beyond what would be discerned from a diagnostic interview alone (Hillman, Sykes, & McConnell, 1998). Finally, biological

methods of evaluating substance abuse can be financially costly, thus making such methods impractical for most clinicians.

Corroborative Evaluation Methods: Collateral Information

More often than not, assessment of trauma history and related psychological sequelae and of substance abuse symptomatology relies on retrospective recall (see Najavits, Weiss, & Shaw, 1997). Numerous researchers have discussed the challenges that reliance on memory poses to accurate diagnostic assessment, specifically with respect to the questionable reliability of retrospective recall. Such issues become particularly salient when applied to the task of attempting to parse out the temporal relationship between trauma and substance-related symptomatology or to understanding interplay among symptoms. In addition, it has been suggested that the self-report of substance use and related symptomatology among substance abusers will be enhanced if individuals are made aware that their self-reports will be verified by other sources (see O'Farrell & Maisto, 1987). Hence, it may be useful for clinicians to broaden assessment to incorporate information from a multitude of corroborative sources, such as friends or family members or documentation from military service or medical records.

EVALUATING OTHER COMORBIDITIES

As previously noted, SUD–PTSD comorbidity has been shown to be associated with higher levels of other Axis I (e.g., depression; Bollinger, Riggs, Blake, & Ruzek, 2000; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and Axis II (e.g., borderline personality disorder, antisocial personality disorder; Bollinger et al., 2000; Krinsley, Young, Weathers, Brief, & Kelley, 1992; Ouimette, Wolfe, & Chrestman, 1996) disorders. Such extensive comorbidity may make it difficult to disentangle and accurately diagnose SUD and PTSD. Hence, any assessment should comprehensively evaluate the presence of other psychopathology. Several of the measures described in this chapter (e.g., SCID, DIS) can be used to evaluate other common comorbidities and symptomatology.

SPECIAL ISSUES

Attend to Nonoverlapping Symptoms

During assessment, clinicians can facilitate greater diagnostic accuracy by attending to symptom overlap and symptom differentiation. Much of the

overlap between PTSD and SUD (both dependence and withdrawal) occurs among avoidance (Criterion C) and arousal (Criterion D) symptoms of PTSD, whereas re-experiencing (Criterion B) symptoms are more specific to PTSD. Saladin et al. (1995) reported that intrusive re-experiencing symptoms (e.g., unpleasant memories, nightmares, flashbacks) demonstrate minimal overlap with substance intoxication or withdrawal.

In cases where the overlap between PTSD and SUD causes difficulty in ascribing symptoms to one diagnosis or the other, it may be helpful to give particular attention to the re-experiencing of symptoms, as the presence or absence of these symptoms may help to distinguish between PTSD and SUD. In cases where hyperarousal and avoidance symptoms are heavily represented, clinicians should be aware that some variance in the experiencing of these symptoms could be due to ongoing substance abuse rather than to traumatic stress sequelae (Saladin et al., 1995).

Establish Temporal Order of Substance Use and PTSD Symptoms

In exploring relations between PTSD and SUDs, some discussion has revolved around the utility of conceptualizing one disorder or the other as *primary*, or as acting as a precipitant of the other (see Stewart et al., 1998). Some researchers have argued that SUDs often evolve in response to traumatic events, citing the preponderance of people with SUDs who previously experienced a trauma (e.g., Kilpatrick, 1990; Resnick et al., 1993; Winfield, George, Swartz, & Blazer, 1990), whereas others have suggested that substance abuse is at least as likely to be the more primary of the two disorders (e.g., Brady, Dansky, Sonne, & Saladin, 1998; Cottler, Compton, Mager, Spitznagel, & Janca, 1992). Regardless of which disorder developed first, there is evidence indicating that temporal order of symptoms may be associated with different clinical pictures (Brady et al., 1998), which suggests that the accurate identification of the primary disorder may facilitate more appropriate treatment planning.

In many cases, however, the primacy of one disorder over the other may not consistently be discernible, and some evidence points to a relationship between these two disorders that is more symbiotic than causal. Many people with SUD–PTSD have a history of early childhood trauma (Najavits et al., 1997; Ouimette et al., 1996; Triffleman, Marmar, Delucchi, & Ronfeldt, 1995). Thus, it is particularly difficult to establish symptoms in relation to a particular Criterion A event, as the event may have occurred too early for current functioning to be realistically contrasted with pretrauma functioning. Furthermore, many people with histories of trauma have experienced not one but multiple traumas (Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Irwin, 1999), and linking posttraumatic sequelae to any single trauma is difficult, if not impossible. For example, a person who presents with apparent

SUD–PTSD symptoms may have experienced combat trauma as well as early childhood trauma. In such a situation it is difficult to ascertain which (if any) of these traumatic experiences was *the* Criterion A event. If someone was traumatized in childhood, then subsequent substance abuse symptoms might be perceived as being secondary to the trauma. Thus, the presence of multiple victimizations makes assessment of symptom onset difficult and at times arbitrary.

It is important for professionals who assess and work clinically with people with comorbid SUD–PTSD to be aware that the genesis of a disorder (i.e., which disorder came first) may not have any bearing on the current clinical picture. Thus, an understanding of the primacy of one disorder over the other may facilitate a clearer understanding of the pathology, but it should not be confused with which symptoms are at present causing the greatest amount of clinical distress or how the symptoms are currently affecting one another. Assessing not only the presence but also the severity of concurrent symptoms (Kofoed, Friedman, & Peck, 1993) will assist in the next step of treatment planning, with the most acute, severe, or debilitating symptoms being attended to first to decrease overall psychological distress and to increase level of functioning.

Explore Relations Between Trauma Symptoms and Substance Use

Research has indicated that specific substances of abuse can be linked to particular posttraumatic symptoms. For example, Bremner, Southwick, Darnell, and Charney (1996) found that patients used specific types of drugs to alleviate different types of PTSD symptoms (e.g., substances such as alcohol, heroin, and other central nervous symptom depressants were used to address hyperarousal and intrusive symptoms). Stewart, Conrod, et al. (1999) reported similar findings and noted that specific substances of abuse were differentially associated with certain constellations of PTSD symptoms. Thus, when one is assessing comorbid PTSD and SUD, particular substances of abuse may provide clues about the extent to which a particular substance may be used by the patient to alleviate specific posttraumatic symptoms. For example, a patient's frequent use of depressant drugs might alert the clinician to pay special attention during the assessment process to hyperarousal symptoms and the ways in which substances are used to medicate these symptoms.

The identification of substances that are used in response to PTSD symptomatology may also indicate the PTSD symptoms that are most problematic for the patient. Specifically, the PTSD symptoms that are most commonly linked to substance use are likely to be those that are eliciting the greatest amount of psychological distress for the patient. It is these symptoms that should be addressed first in treatment.

A client's perceptions of his or her symptoms and how these symptoms affect one another are also a valuable source of information. Simply asking patients if symptoms are related to trauma or if they may be related to substance use will help a clinician understand symptom constellations (Saladin et al., 1995). This was exemplified in a study by Brown, Stout, and Gannon-Rowley (1998), who found that patients with SUD–PTSD perceived the relationship between the two disorders to be interconnected and reported that when symptoms from one disorder either improved or became worse, symptoms from the other disorder moved in the same direction. Moreover, regardless of the accuracy of the information pertaining to the connection among symptoms, client *perceptions* about how the two disorders relate to one another is valuable clinical information and may be helpful in addressing the client's motivations for change. For example, if the client recognizes that PTSD symptoms are likely to worsen with continued substance use, then he or she may be more motivated to engage actively in treatment for substance abuse.

Be Sensitive to Stigmatization and Shame

Both victimization status (particularly sexual victimization) and substance abuse are associated with significant societal stigma (Imhof, 1996). Such a stigma can present a challenge in the process of assessing PTSD and SUDs. For example, clients who wish to avoid being labeled an alcoholic or an addict may minimize either the quantity or frequency of their drinking as well as the extent of consequences resulting from substance use (Vuchinich, Tucker, & Harllee, 1988). Concern about encountering stigma or bias may similarly influence patient reports of both trauma and substance abuse history. For example, in a study conducted by Brown et al. (1998), more than half of the patients with SUDs and PTSD indicated that shame and blame were critical deterrents to seeking psychological treatment. On a related note, more than one third of the study participants identified lack of trust in the treatment provider as another potential barrier to treatment seeking. These data underscore the importance of providing a safe and validating environment for the assessment to take place.

Attend to the Assessment Context

Shame and stigma are not the only factors that may lead to the underreporting or misrepresentation of trauma and substance abuse symptomatology. Contextual factors, such as being court-ordered to treatment, seeking disability or other financial compensation, or even cultural mores also can affect an individual's self-report of PTSD and SUD symptoms. Specifically, gender differences have been identified in symptom reporting

such that women are more likely to report greater symptomatology across several areas of distress than are men (Kroenke & Spitzer, 1998; Sheridan, Mulhern, & Martin, 1999). Cultural differences regarding behaviors that are deemed acceptable or unacceptable for different genders regarding sexual behavior and substance use can also affect reporting of victimization history, trauma-associated sequelae, and substance use (Wolfe & Kimerling, 1997). For example, men may be more ready to report combat trauma than they are to report interpersonal trauma. In addition, people seeking financial compensation may be more likely to report PTSD symptoms (Frueh, Gold, & de Arellano, 1997; Frueh, Smith, & Barker, 1996). Conversely, substance abuse symptoms may be less frequently reported if patients fear that the stigma and blame associated with SUDs will negatively affect their chances for financial compensation. Clients who are seeking treatment because of pressure from employers, the criminal justice system, or family members may minimize any kinds of symptoms in the interest of presenting themselves in a more positive light. Thus, it is important for clinicians to be aware of the context or circumstances surrounding the assessment referral (Vuchinich et al., 1988).

Particularly for clinicians working with combat veterans it is important to understand specific aspects of the military culture that may contribute not only to current substance use patterns but also to the individual's attitude toward his or her substance use and resulting openness to treatment. For example, some veterans may believe that alcohol and drug use were encouraged or condoned in the military environment. Thus, it is possible that substance use may continue to be viewed as an accepted and adaptive way of coping with stressful or traumatic events. If an individual perceives his or her substance use as a normal way of coping with a traumatic event, then he or she may be likely to underestimate or minimize substance abuse symptoms or associated consequences.

Take Steps to Minimize Relapse or Worsening of Symptoms

Among SUD patients, comorbid PTSD is associated with higher rates of SUD relapse (Ouimette, Ahrens, Moos, & Finney, 1997). Although the specific mechanisms of why this comorbidity may lead to relapse are as yet unknown, it is likely that an individual's perceived inability to cope effectively with traumatic memories and trauma-related sequelae may at least partially explain this phenomenon. The process of assessment of PTSD clearly has the potential to activate traumatic memories and trauma-related symptoms and, as a result, may serve to create urges to use substances to cope with this symptomatology. Thus, clinicians need to explain to patients that they may experience an increase in symptoms as a function of the assessment and should develop contingency plans (e.g., behavioral contracts)

and strategies (e.g., coping skills training; Monti, Rohsenow, Colby, & Abrams, 1995). The assessment process should include an evaluation of specific situations likely to trigger substance use, with particular attention to PTSD symptoms and the role that these serve in relation to urges to use. Conversely, it is also valuable to understand the extent to which substance use patterns are associated with PTSD symptoms, as it is possible that substance use may serve as a trigger for PTSD symptoms. Before the assessment begins, psychoeducation regarding what the assessment process entails should be offered to prepare the client for potential challenges that may arise.

PROVIDER ISSUES

In a literature review, Ouimette, Brown, and Najavits (1998) posited several reasons why clinicians may fail to sufficiently screen for and document PTSD in substance abuse treatment settings. Such reasons included underestimation of the effects of trauma and related sequelae, discomfort in discussing sensitive issues such as trauma, the belief that substance abuse symptomatology should be attended to prior to addressing other comorbid psychological issues, and insufficient knowledge or training. PTSD treatment providers may also be reluctant to inquire about substance use patterns, possibly fearing they will overwhelm clients or believing that substance use problems will automatically dissipate with PTSD treatment. Moreover, despite the prevalence of SUDs in PTSD populations (Escobar et al., 1983; Keane, Gerardi, Lyons, & Wolfe, 1988), some PTSD treatment providers may shy away from inquiring about substance abuse for fear that they lack the necessary expertise to adequately address such issues should they arise.

Providers should be aware of potential barriers to comprehensive assessment and should take steps to address these barriers in the interest of providing optimal care for clients at risk for comorbid SUD–PTSD. For example, as we have underscored in this chapter, clinicians should bear in mind the importance of concurrently evaluating SUD–PTSD instead of triaging assessment and focusing only on one disorder or the other. Furthermore, in the interest of overcoming shyness or embarrassment about potentially sensitive topics (i.e., trauma history, problematic substance use), clinicians should work with clients to establish a common language through which trauma and substance abuse experiences and symptoms may be described. This terminology should be described clearly and operationalized at the outset of the assessment process so that it is clear to both clinician and client. Terms should be behaviorally specific to maximize accuracy. The use of a specific and agreed-on common language will increase the likelihood of collecting accurate trauma and substance use data. Furthermore, such specificity will also help to normalize discussion about these topics.

ONGOING ASSESSMENT

Assessment of comorbid SUD–PTSD is not limited to the initial formulation of a diagnosis. Indeed, in addition to assessing for relevant symptoms to formulate a clinical diagnosis, clinicians should conduct an ongoing assessment to track changes in the presence and severity of symptoms. Ongoing assessment can be behavioral—measuring actual drinking behaviors or the presence of observable re-experiencing, avoidance, or arousal symptoms—or it may focus on more internal, cognitive, or emotional factors (e.g., urges to drink, difficulty concentrating, feeling as if a traumatic event is recurring). Outcome assessment should also evaluate patient progress with respect to functional impairment (i.e., the extent to which social or occupational functioning continues to be affected). Clinicians should also continuously assess relations between PTSD and SUD symptoms, with an eye toward how the amelioration or exacerbation of one set of symptoms may affect the other symptoms. One method of assessment that lends itself particularly well to developing an understanding of symptom interplay is the self-monitoring of symptoms (Shiffman, 1988). By maintaining an ongoing log of PTSD and SUD symptoms, clients and clinicians will be able to observe changes over time as well as interactions between symptom constellations.

Ongoing assessment also allows clinicians not only to evaluate client progress but also to think about this progress with respect to the diagnostic and treatment choices that were made during assessment. Specifically, through ongoing assessment, diagnostic and treatment planning decisions may be re-evaluated or tweaked in light of new developments in symptom presentation (Ruzek, Polusny, & Abueg, 1998).

SUMMARY AND CONCLUSION

Comprehensive assessment of comorbid SUD–PTSD represents the first step toward providing adequate care for people with these concomitant diagnoses. We have provided some guidelines that may enhance the accuracy of the assessment process. For example, taking such steps as assessing for PTSD and SUDs concurrently, as well as approaching the assessment process with an open mind and an awareness of other commonly comorbid diagnoses, will enhance the likelihood that important presenting symptoms are not overlooked or misdiagnosed. Screening questions for PTSD should be standard practice in all SUD treatment facilities and, conversely, PTSD treatment providers should routinely screen for SUDs among their clients. Atkinson, Henderson, Sparr, and Deale (1982) advised clinicians to make all justifiable diagnoses and to clearly associate specific symptoms with each

diagnosis. Thus, clinicians should strive for accuracy over parsimony, applying multiple diagnoses if there is sufficient evidence rather than attempting to distill complex diagnostic symptom presentations into one or two simple clinical categories.

We underscore the importance of uncovering as much information as possible about the nature of and relationship among particular symptoms. To this end, strategies such as distinguishing overlapping (i.e., shared by both PTSD and SUDs) from nonoverlapping symptoms, exploring relations between trauma and substance abuse symptoms, and differentiating trauma history from PTSD are offered as a means to determine how specific symptoms may relate to a particular diagnostic category or to one another.

Understanding the context in which a client is being assessed will facilitate a clearer understanding of both the client and his or her diagnosis. Awareness of and sensitivity to contextual factors (such as the circumstances under which a patient is being evaluated, or cultural factors that may contribute to a sense of shame and stigmatization) will help minimize the possibility that such factors will bias symptom reporting. Finally, the way clinicians approach the assessment process (e.g., planning for the ways in which the assessment process may trigger worsening of symptoms or relapse, implementing ongoing assessment throughout treatment) are apt to make for a smoother evaluation and better continuity of care.

A more comprehensive approach to assessment of comorbidity can help patients begin to connect PTSD and SUD symptoms and to help them develop a model of etiology, symptomatology, and treatment. To this end, clients should receive education about both PTSD and SUD (Kofoed et al., 1993). Moreover, clinicians working with these clients should seek to validate their experiences with these two disorders and should help them understand the meaning of this comorbid diagnosis. In particular, some patients may not even be aware that it is possible to carry two diagnoses at the same time. Thus, any information that clinicians can provide to enhance the client's understanding is likely to be useful in assessment and in subsequent treatment.

The relationship between substance use and PTSD is clearly complex, which can present numerous challenges to clinicians working with at-risk clients. Furthermore, although research attempting to explore this comorbidity has increased dramatically over the last 10 years, much still remains unknown about working clinically with this population. This chapter represents an effort to present what has been established in the existing literature with respect to assessing and diagnosing comorbid SUDs and PTSD. An awareness of the commonalties and differences between these two disorders, as well as the ways in which they may affect one another, will help clinicians to provide a more comprehensive and accurate assessment for this high-risk population.